Exhibit I

Deposition of:

Rebecca Betensky , Ph.D.

July 26, 2016

In the Matter of:

Clare-Austin vs. C.R. Bard

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Q. But it was clear, even if you didn't perform the exact calculations, it was clear that the frequency of these reported adverse events was not huge; correct?

MR. MANKOFF: Object to form.

A. Correct, relative to the reported sales numbers and the reported events, that's correct.

Q. Now, you've been using and we've been using interchangeably as you said reported risk ratio, that term, with reported relative risk. How does a reported relative risk differ from a relative risk?

A. So the qualifier "reported" is important, and that's indicating that the data are coming from reports, and are not being derived from a beautifully run and designed experiment like a clinical trial, in which there's perfect follow-up and in which it's really a true experiment.

So the "reporting" qualifier is there to say and to suggest that these are numbers that are reported. These are based on reports.

Q. And that's different from a true relative risk; correct?

A. A relative risk, which is what the target is, which is what would be of interest, wouldn't be entangled with issues around reporting.

Q. And we don't know whether that occurred in this instance with this particular data set, do we?

MR. MANKOFF: Object to form.

A. We don't whether what occurred?

Q. Underreporting or overreporting. You said it could lead to it.

A. No --

Q. We don't know whether it led to either way in this case, do we?

A. I'm sorry; I said --

MR. MANKOFF: Just let the court reporter catch up.

Object to form.

A. Okay. I didn't say anything about overreporting. What I said was overestimates. So these data could -- they provide an estimate, we call it the reporting risk ratio. And this estimate could be an overestimate or it could be an underestimate.

Q. Okay, and I stand corrected. Let me rephrase that question.

And we cannot say, sitting here today, whether the reported relative risk that you calculated overestimates or underestimates in this particular data set, can we?

respect to that is just looking at the sales data over time across ten years of time for some products, and less so for others because they were removed from the market earlier. The sales data seems pretty constant month by month, which is the granularity at which I have the data.

So I would imagine that these are expensive devices and nobody wants too many of them sitting on the shelf; and so over time, institutions or physicians learn better how to estimate their needs, and so that wouldn't be a very big problem.

So I did also address that through one of my sensitivity analyses, and just assumed -- or just considered what would happen if I discounted the sales data by 20 percent and just assumed that 20 percent are sitting on the shelf and 80 percent are implanted, and I obtained comparable results to when I didn't do that discounting.

Q. Other limitations?

A. So another limitation is that these are crude estimates of risk and reflect different times of exposure to devices, partly due to when the SNF, for example, was available prior to the start time of 2000; also reflecting the permanent versus retrievable issue.